Instructions for using the PDF File for the Jail Survey.

Option 1 - Electronic Mail Submission

Complete form using Adobe Acrobat
Click on "File", located in the upper left corner of Adobe Acrobat
Select "Save a Copy" - Save document to desktop
Attach this saved document to your email to Laura.Cortina@dhs.gov

Option 2 - Enter into Adobe Acrobat Form and Fax or Mail

Fill out form
Click on the "Print" icon to print out completed Form
Fax to 202-514-0095 or return with Self Addressed Stamped Envelope

Option 3 - Fill out Form manually and Fax or Mail

Click on "Print" icon to print blank Form
Fill out manually
Fax to 202-514-0095 or return with Self Addressed Stamped Envelope

Bureau of Immigration and Customs Enforcement (ICE)'
Survey for Contract Jail Profile

The Division of Immigration Health Services, on behalf of ICE, is requesting your participation in completing this questionnaire to aid in the placement of detainees by collecting information on available health services resources at jails and detention facilities used by ICE throughout the country.

1. Facility Name:_____Date:_____

Address:_____

_____ ZIP:_____

Phone:(___) _____

FAX: (___) _____

Contact Person:_____ Phone:(___) _____
(primary person to contact for follow up to responses)

Warden or Superintendent: _____

ICE Officer at facility ( ) yes ( ) no if yes, Contact Name: _____ Phone:_____

2. Jail Capacity:
a. Total jail capacity: _____
b. Number of beds available for ICE detainees:_____
c. Male detainee beds:_____
d. Female detainee beds:_____
e. Juvenile detainee beds:_____

3. Healthcare Staffing:
Person in charge of health services:_____Phone:_____
Please tell us which provider services are available on-site and off-site. For on-site services, please indicate the approximate hours per week that each provider is available.

	On-site Provider # hrs/wk	Off-site Provider
a. Physician (MD/DO)	_____	_____
b. Nurse Practitioner/Physicians Assistant (NP/PA)	_____	_____
c. Registered Nurse (RN)	_____	_____
d. Licensed Practitioner Nurse (LPN/LVN)	_____	_____
e. Dentist (DDS)	_____	_____
f. Psychiatrist	_____	_____

[1] ICE was formerly known as Immigration and Naturalization Service (INS)

3. Cont'd

g. Psychologist	_____	_____
h. Social Worker	_____	_____
i. Clinical Counselor	_____	_____

On-site Care Profile

4. Ambulatory (outpatient) services: ( ) yes _____hours/day ( ) no

5. Inpatient/Infirmary: ( ) yes ____ #beds ( ) no If yes, is this a 24/7 infirmary? ( ) yes ( ) no

6. Respiratory Isolation (negative pressure units): ( ) yes ____ # beds ( ) no

7. Medical Isolation: ( ) yes ____ # beds ( ) no

8. If dental services are provided on-site, is the dentist ( ) full time ( ) part time ____ hrs/wk

Dentist Name:_____

Phone:_____

9. If dental services are provided off-site, please provide the name/address of all dental providers.

_____
_____
_____

10. Is your facility wheelchair accessible: ( ) yes ( ) no
If yes, is the entire facility wheelchair accessible? ( ) yes ( ) no

11. Renal Dialysis Availability: ( ) on-site ( ) off-site ( ) none

12. Is the correctional staff and the healthcare staff trained, experienced and competent to manage persons on hunger strike? ( ) yes ( ) no

13. Is your facility equipped to force feed? ( ) yes ( ) no

14. Are your healthcare providers trained to force feed? ( ) yes ( ) no

15. If no, is there a hospital, or medical facility close by which will force feed? ( ) yes ( ) no

Name of facility:_____

Phone:_____

Off-Site Care Profile

16. **Types of Specialty Consultants:**

a. _____ b. _____

c. _____ d. _____

17. **Emergencies: (Where referred)**

a. _____ b. _____

18. Hospitals: Indicate type - if primary (community), secondary, or tertiary:

a. _____ b. _____

c. _____

Services

Health Appraisal:

19. Laboratory capability: ( ) yes, if so ( ) on-site, or ( ) off-site ( ) no

20. Radiographic capability: ( ) yes, if so ( ) on-site, or ( ) off-site ( ) no

21. Do you have tele-health capabilities? ( ) yes ( ) no
If yes, please check your capabilities:
_____tele-radiology
_____tele-psych
_____tele-medicine
_____video conferencing
_____Other: _____

Access to Health Care:

22. Sick call is provided ( ) on-site ( ) off-site

23. Number of days per week that sick call is provided: _____

Pharmacy:

24. Pharmacy services on-site: ( ) yes ( ) no
If no, do you use a mail-order service? ( ) yes ( ) no

Please provide the name of your pharmacy service/contractor: _____

Dietary:

25. Are medically prescribed diets prepared? ( ) yes ( ) no

26. Indicate which diets are available: ( ) low salt ( ) diabetic ( ) low fat ( ) other

Mental Health

27. Psychiatric Observation: ( ) yes ____ # beds ( ) no

28. Mental Health Unit/Ward ( ) yes ____ # of beds ( ) no

29. Psychiatric Facilities:

a._____ b. _____

30. Name of psychiatric hospital utilized if your site does not have mental health ward:

Name of Institution: _____

Address: _____

_____

Phone: _____

31. **Mental Health Services Offered:**

a. Pharmacotherapy	( ) Yes	( ) No
b. Psychotherapy	( ) Yes	( ) No
c. Group Therapy	( ) Yes	( ) No
d. Crisis Counseling	( ) Yes	( ) No
e. Case Management	( ) Yes	( ) No
f. Discharge Planning	( ) Yes	( ) No
g. Anger Management	( ) Yes	( ) No
h. Psychological Tests	( ) Yes	( ) No
i. Psychosocial	( ) Yes	( ) No
j. Substance Abuse	( ) Yes	( ) No
k. Sexual Offender	( ) Yes	( ) No
1. Domestic Violence	( ) Yes	( ) No

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Infectious Diseases/Screening and Reporting

32. What method of TB screening is used as a first line screening test?
_____PPD _____chest x-ray

33. If PPD, how soon after arrival do you plant the PPD? _____

34. If chest x-ray, how soon after arrival do you take the x-ray? _____
how soon after taking the x-ray do you receive results? _____

35. How soon after arrival does the detainee get his/her housing assignment? _____

36. Where are detainees housed while awaiting PPD results? _____

37. What other infectious diseases do you routinely screen for?
_____

38. Do you report TB to the local health department? ( ) yes ( ) no

39. Do you report other infectious diseases to the local health department? ( ) yes ( ) no

40. Local health department name: _____

Local health department telephone #: _____

Local health department fax #:_____

41. When is initial Health Screening performed?
First 24 hours _____
Within 2 days _____
Within 4 days _____
Within 7 days _____
Within 14 days _____

42. Are complete physicals performed as defined by NCCHC guidelines? ( ) yes ( ) no

This completes our Questionnaire! Thank you for your participation! If you have any questions concerning the content of this questionnaire, please do not hesitate to contact us at:
(888) 718-8947